BONE DENSITOMETRY QUESTIONNAIRE

Name: _____ Date: _____

DOB: _____ Referring Physician: _____

Height: _____ Weight: _____

Race: African American _____ Asian _____ White _____ Hispanic _____

Native American _____ Other _____

Are you presently being treated for Osteoporosis? _____

Current Medications (i.e.: Fosamax, Calcitronin): _____

Steroid Use: (Prednisone, other) Yes _____ No _____ Dose_____mg.

How long on drug therapy? _____ Is therapy completed? _____

L.M.P._____ Menopause: Yes _____ No _____ At What Age? _____

Hysterectomy: _____ Partial: _____ Complete: (ovaries removed) _____ HRT _____

Thyroid/Parathyroid problems: _____

Other Diseases:_____ Pain: _____ Arthritis: _____

Did a prior x-ray show bone loss? _____ Adult Fractures: _____

Allergies to milk products: _____ Smoker: _____ Non-Smoker: _____

Exercise: _____ What type: _____ How often: _____

Previous bone density scans? _____ When: _____ Results_____

Reason for today's test? _____

Patient Signature_____

Tech: _____